What to Know When Transitioning to Sanford Health Plan

SANFORD HEALTH PLAN

Welcome to Sanford Health Plan. We want to make you aware of these options for your health care into the Sanford Provider Network established by your insurance plan. **If your provider is already in the Sanford Health Plan Network, no action is needed.**

	Our Experience Guarantee	Transition of Care	Continuity of Care
What is it?	If you are a member of a qualifying employer group* who is joining Sanford Health Plan, you have a 90-day Experience Guarantee. This means you have 90 days from the effective date of your Sanford Health Plan insurance coverage to attend previously scheduled appointments with out-of-network providers while still being covered at an in-network rate. The Experience Guarantee is available to help you transition to a provider within your new Sanford Health Plan provider network.	With transition of care, you will be able to continue receiving services for qualifying medical and behavioral conditions with health care providers who are not in your plan's network, at in-network coverage levels. This short-term care may continue for a defined period of time until the safe transfer of care to an in-network doctor or facility can be arranged.	With continuity of care, you may be able to continue to receive services at in-network rates beyond 90 days on a case-by-case basis. There must be legitimate clinical reasons preventing transfer of care to an in-network health care provider. Your treating provider must provide a letter of medical necessity indicating extenuating circumstances that may not be fully met by in-network providers beyond the 90-day transition period.
How does the member get it?	The 90-day Experience Guarantee is available to you automatically. No application or medical record review is needed.	You must complete the transition of care application located at SanfordHealthPlan.com **within 90 days** of the plan's effective date or your Provider's termination date. Medical records may be required to determine eligibility.	Continuity of care requires prior authorization from your provider and a full medical record review to determine if medical criteria are met and there is a clinical reason preventing transfer of care to an in-network provider.
Who is eligible?	All members in the group	If you are affected by one of the following and your current provider is not in our network, you may be eligible for a short-term transition of care: 2nd or 3rd trimester pregnancy, scheduled surgery, cancer treatment or transplant services or other services where it would be deemed harmful to transition at this point of treatment.	Your provider is not in-network and there is a clinical reason preventing transfer of care to another health care provider.
When does it start?	Starts on the new group's plan effective date	Upon approval by the transition of care team following a review of the application and medical records	Upon approval by the Medical Director/ Utilization Management department after a complete review of the Prior Authorization request, medical records, and letter of medical necessity from your treating provider. You must be eligible and enrolled on the plan for this process to occur.
When does it end?	Ends after 90 calendar days from the plan's effective date	On the date listed in the approval letter; this is short-term until the clinical need has ended and/or the safe transition to an in-network provider.	On the date listed in the approval letter

*For qualifying large employer groups. Available for self-funded groups only if elected by the employer.

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